Response

Dr Steben is correct in that the photograph of the patient with pathologic phimosis has concurrent balanitis xerotica obliterans (BXO) or lichen sclerosis et atrophicus. In the pediatric age group there is an association between the two. This does not represent a "diagnostic error," however. Although the BXO might respond to high-potency topical steroids, it has been our experience, and that of others, that the scarred phimotic ring rarely does.[1] Balanitis xerotica obliterans might require treatment with topical steroids for a time after circumcision, but in most cases removing the pathologic foreskin will resolve the problem. The risk of cancer of the penis with BXO is not pertinent to the pediatric age group, as the condition is reversed by timely circumcision with or without topical steroid application. The biggest risk in children is the development of meatal stenosis secondary to BXO, which might require meatotomy.

—Michael P. Leonard MD FRCSC FAAP
Ottawa, Ont
by e-mail

Reference

1. Webster TM, Leonard MP. Topical steroid therapy for phimosis. *Can J Urol* 2002;9(2):1492-5.

We cannot market the unsaleable

The Commentary article by Ivers and Abdel-Galil[1] about improving marketing of family medicine is a praiseworthy attempt to put a brave face on family medicine's poor reputation. Their solution, to "make a good offence, and change the perception of family medicine" is good as far as it goes, but it is a salesman's approach. Sadly, even the best marketer finds it difficult to sell a second-rate product: like North American cars, when Japanese brands are available.

Even worse, the idea of selling niche-market family medicine to those who find the main approach unattractive is avoiding the real issue. Medical students and their in-hospital preceptors are not fools. They can see the reality. Yes indeed, family medicine does include many who came into it because we love what we do and try our hardest to do it well. But it also includes many who trained in our specialty because the system would not let them do what they really wanted. Some of these accept the station in life to which the Canadian Resident Matching Service has called them, others move into niche practice close to what they wanted, while others become "bottom-dwellers," aiming to get away with the minimum work at maximum speed for maximum pay. Their patients are overrepresented among the patients seen by specialists, with inappropriate referrals, poor diagnoses, and unavailable follow-up, so biasing the perception of family medicine overall.

Sadly, when the pay and conditions for community-based, continuing, comprehensive family medicine are so much less desirable than those for many of the specialties, it is unreasonable to expect bright young people with debts and family commitments to join our ranks. Some of those who entered with high ideals feel let down when the reality sinks in.[2] Most of the discussion about earnings is misleading; even if family physicians earn 80% of specialists' gross income, their office overheads and the cost of paying back debt and feeding a family are similar, leaving specialists with a disposable income several times higher. If a gastroenterologist has an entry salary of $252 000, that is more than a full professor of family medicine can currently hope to earn. Someone must have decided that this disparity has some relationship to our value to society. How can I as a professor honestly tell undecided students that they should join our program and thereby earn much less than if they spent an extra year or two training in most other fields? And if they graduate in family medicine, they find that niche practice pays better and provides a better lifestyle. Yes, the personal rewards of family medicine work are wonderful, but I have heard